Member Billing Form

Customer Service

1-800-662-6667
711 (TTY users)

8 a.m. to 5:30 p.m. Monday through Friday

HOW TO USE THIS FORM

This form is for bills you receive from providers who don't participate with us. Use it to send us a bill that you haven't paid. Use one form for each bill you receive. Send to:

Member Claim Inquiry – C225
Blue Care Network
P.O. Box 68767
Grand Rapids, MI 49516-8767

If you paid the bill, call Customer Service, and ask for our Member Reimbursement form. You can also get a form online at **bcbsm.com/billform**.

Keep a copy of everything you send us.

MEMBER INFORMATION

Patient name			Date of birth	
Subscriber name		Contract no.		
Address		City	State	ZIP Code
Phone	Day — Evening —	PCP who wrote referral	PCP number (if known)	

SERVICE INFORMATION

1. Was the service rendered on an emergency basis?	☐ Yes	☐ No
2. Was your BCN primary care physician notified?	☐ Yes	☐ No – Explain below
3. Were you referred to the attending provider by your primary care physician?	☐ Yes	☐ No – Explain below

Explain why services were not performed by a BCN participating provider.

Explain the circumstances regarding this service. (Attach additional sheets if necessary.)

I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT.

Subscriber's Signature	Date